STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING: _____ B. WING _____	03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

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4 000	Initial Comments A re-licensing survey was conducted by the Office of Healthcare Assurance (OHCA) on March 18, 2021. The facility was found not to be in substantial compliance with Hawaii Administrative Rules (HAR) Title 11, Department of Health Chapter 94.1 Nursing Facilities. One complaint was investigated Aspen complaint tracking system (ACTS) #8018 and was not substantiated. Survey dates: March 16 to 18, 2021. Survey Census: 27. Sample size: 12.	4 000		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observation, interview and record review, one Resident (R)5 acquired a stage four pressure injury while residing in the facility. In	4 136		

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spite of the appropriate and timely wound treatment, and dietary interventions to address the wound, progressed to a stage four pressure ulcer of the coccyx. Surveyor made multiple observations from 03/16/21 to 03/18/21 and noted that R5 was lying in the same position for a minimum of three to three and one half hours. Timely turning and repositioning of the resident is crucial to promote wound healing and avoid continuous pressure on the existing injury. The deficient practice resulted in poor healing and worsening of the stage four coccyx injury and R5 was subjected to painful treatment and acquired infections that exacerbated the treatment outcome. The deficient practice failed to provide R5 with the highest practicable physical well being while residing in the facility.

Findings include:

Surveyor reviewed the electronic medical record (EMR) on 03/16/21 at 4:54 PM. Per the wound weekly observation tool dated 03/12/21 at 15:02, resident has a stage four pressure injury to the coccyx that is facility acquired. 1.8 cm L X 1.0 cm wide X 1.5 cm deep. Undermining from two to three o'clock position, with pink tissue. Current treatment and dressing provided.
R5 is a disabled, male adult resident totally dependent on staff for bed mobility.

Surveyor reviewed the EMR on 03/17/21 at 11:49 AM.
Progress notes dated 09/02/20 17:42. Skin: Skin warm & dry, resident has current skin issues. Pressure Ulcer/ Injury. Skin issue Location: Coccyx Pressure Ulcer / injury Stage IV full thickness tissue loss. Wound Bed: Granulation. Wound Exudate: Serosanguineous. Peri Wound Condition: Fragile. Dressing

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saturation: Minimal (<25%). No wound odor. Tunneling present. Undermining noted. Clinical suggestions: Evaluated for pain, discomfort. Dressing changes/treatments performed as ordered. Resident is turned, ambulated, moved at least every 2 hours.

Surveyor observed R5 in his hospital bed in the primary activity area on 03/17/21 at 12:47 PM. Noted head and shoulders facing to the right, on his back. The Registered Nurse (RN) 1 stated that she will do his dressing change around 2 PM after she give's his suppository and he has his bowel movement (BM).

03/17/21 at 01:25 PM R5 was in his bed in his room head and shoulders facing to the left side. Per RN, she just gave the suppository, and will change the dressing after his BM.

Surveyor made the following additional observations on 03/17/21:
2:30 PM, same position, facing to his left side.
3:07 PM, same position, facing left side.
3:40 PM same position, facing left side.
430 PM facing left side.

Surveyor received and reviewed thinned paper progress notes on 03/17/21 at 12:50 PM.
11/09/19. Daily skilled nurse's note. Coccyx wound closed with pinpoint scab.
11/29/19. Coccyx wound dressing changed after bath. Scant amount of purulent drainage noted to old dressing, no odor, no s/s infection.
12/05/19. No change to care of pressure ulcer coccyx wound, dressing changed, wound culture ordered and sent, pending results.
12/09/19. New order for Bactrim DS via GT BID x 14 days, diagnosis (DX): Coccyx wound infection.

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4 136	Continued From page 3 03/19/20. Coccyx wound bed continues pink, no drainage, no signs symptoms of infection. Per wound consultant, coccyx wound closed with fragile scar tissue. 04/23/20. Seen by wound consultant (WC) measured 0.4 cm X 0.2 CM 0 0.2 cm with signs of improvement. 05/14/20. WC, coccyx wound perimeter with maceration, wound bed is with dark pink tissue, wound measurement 0.5 cm x 0.2 cm depth 0.3 cm, mom was updated with new order of the coccyx wound treatment. 06/04/20. New order for new coccyx wound treatment (tx) due to (d/t) worsening. New measurements 1.1 cm L x 0.4 cm w X 0.3 cm D. 06/18/20: Wound consultant came by today, coccyx wound measures 1.1 x 0.6 cm. 07/09/20: Coccyx wound continues with slight opening, blood noted to old packing strip, New order for Ciprofloxacin, & intravenous (IV) Ampicillin. and Lidocaine for debridement. Coccyx wound measures 0.9 cm x 0.8 cm x 0.4 cm. with undermining. 07/30/20: Debridement to coccyx wound. remove dead tissue. 08/06/20: Coccyx wound with soft eeschar noted. wound bed 1.4 cm X 1.2 cm. Depth 0.5 cm. underminined with 3 o ' clock 0.2 cm. 08/15/20: Coccyx wound was debrided by WC, measured 2.7 cm X 1.5 cm X 0.7 CM x 0.6 cm underming to 2 o ' clock. New order for coccyx wound. 08/17/20: WC came to debride residents coccyx wound, measurements 2.9 cm x 2.8 cm x 0.8 cm. Labs ordered DX: Chronic wound.	4 136		

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4 136	Continued From page 4 Surveyor reviewed the Registered Dietician (RD) notes on 03/17/21 at 2:52 PM. 11/29/20 nutrition/dietary note. Resident is at risk for poor wound healing his nutrition needs to be maximized without causing excessive weight gain. Goal to provide appropriate nutrition and hydration for optimal health with total G-Tube (GT) feeds. Maintain weight between 58-61 kilograms (kg). P: Continue with Peptamen 1.0 at 250 milliliters (ml) x 4 day at 125/ml per hour. Continue with Arginaid 1 packet day continue with Beneprotein 2 packets continue with multivitamin. 12/19/20 Nutrition/dietary note. Recommendation. Start 1 packet of Juven/day. 02/27/21 Nutrition/ Dietary Note: Resident appears stable in weight. He has been stooling 1-2 x day no loose stools noted. Continue current plan. Surveyor observed R5 on 03/18/21 at 07:06 AM lying on his left side with pillows propped on his side and between his knees. Surveyor made the following additional observations on 03/18/21: 08:00 AM, R5 facing to the left looking toward the window with his neck hyperextended. 08:40 AM R5 in same position facing to the left looking toward the window with his neck hyperextended. 09:33 AM R5 in same position facing to the left looking toward the window with his neck hyperextended. 10:21 AM R5 in same position facing to the left looking toward the window. Surveyor observed a dressing change on	4 136		

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4 136	Continued From page 5 03/18/21 at 10:29 AM Present were RN2 Marilyn, Director of Nursing (DON), and the wound care nurse consultant by cell phone face time so she was able to watch and assess the wound while RN2 did the dressing change. Surveyor asked RN2 what are the interventions nursing staff are doing to prevent worsening of the pressure ulcer, she replied that the wound nurse sees him weekly and the RN and certified nurse aide (CNA) are turning him every two hours.. The DON added that R5 also has a pressure relieving mattress. We are turning him side to side at least every two hours. he is also on Juven (a formula to promote wound healing). Surveyor asked if the resident has pain, if so, how is it being treated. The RN2 replied that he isn't having any pain now. The WC stated when we debride the wound he receives pain medicine via the G-tube and lidocaine topically. Surveyor asked the WC when did the current pressure ulcer (PU) develop and what caused the PU. The WC replied it started In August of 2019. R5 has been challenged because of bacteria that enters the wound during his frequent bowel movements. He has been on a few different antibiotics for infection. The area on the coccyx was open previously. Every week I'm doing a sharp debridement of the wound that seems to be helping, then thought we had some problems with protein issues. He is now on a vitamin D supplement. A big issue is he has quite a few BM's in a day. The staff are doing a good job putting that dressing on, and are able to keep the feces out of the wound. Surveyor asked what are the interventions to prevent the wound from worsening and improve. The WC replied, no shearing, when the nursing staff are rolling him they need to avoid pulling him up on that wound. Keep the dressing clean and no feces in the wound bed. We did get the	4 136		

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4 136	Continued From page 6 Dietary consult and the RD adjusted his nutrients to include more protein and vitamin D. Keep him clean and dry, making sure the dressing is intact. If staff notice a sign of infection they are to report it to the DON and Wound nurse immediately. Surveyor asked how important it is to turn R5 every two hours, she stated that it is very important. Surveyor asked if the pressure ulcer is preventable and she said yes I would say it is. In this case very challenging to do but preventable. Surveyor asked what interventions were in place before the PU developed. The WC replied turning him regularly and keeping him clean. Surveyor noted at 10:40 AM R5 was turned onto his right side for the dressing change. At 11:57 AM, noted staff brought R5's bed out to the activity area, where he was facing to the right side. Surveyor made the following additional observations on 03/18/21: 12:45 PM R5 in same position in his bed facing the right side. 1:34 PM R5 in same position facing to the right side. 1:53 PM R5 is back in his room, same position facing to the right side.	4 136		